APPLICATION FOR LICENSE AS A LICENSED MARRIAGE & FAMILY THERAPISTS

GEORGIA STATE BOARD OF PROFESSIONAL COUNSELORS, SOCIAL WORKERS, AND MARRIAGE & FAMILY THERAPISTS
Post Office Box 13446
Macon, Georgia 31208
Phone (478) 207-2440
www.sos.state.ga.us/plb/counselors

Please read the instructions carefully and be familiar with the laws and rules governing the practice of Marriage & Family Therapy in the State of Georgia. Visit the following web site for information: http://www.sos.state.ga.us/plb/counselors

****Important****

The Board cannot process incomplete applications. If any item is missing, incomplete or incorrect, your application cannot be reviewed by the Board. Please review this application before you submit it to ensure that all information and documentation is complete and correct. Incomplete applications result in delayed processing. Incomplete applications are void after one year.

Application Checklist

The following checklist is an important part of your application. Please use this checklist to ensure that you submit a COMPLETE application.

The **non-refundable application fee** made payable to Georgia Professional Counselors, Social Workers, and Marriage & Family Therapists must be included with the application. (please see Fee Schedule at the Board's website)

Please access the Board Rules which includes licensure requirements from our website at www.sos.state.ga.us/plb/counselors

Application Checklist

- ❑ **NOTARIZED APPLICATION:** The eight-page application must be mailed to the Board's office at the address listed above, along with your **FEE**. All questions must be answered. Any question answered "yes", requires further documentation to be submitted. Request official court documents be submitted to the Board and provide an explanation if you have had any criminal convictions or charges, or sanctions by another state licensing board. The Board will review a complete application with all required documentation at their next scheduled meeting. Approval of licensure is at the Board's discretion.

- ❑ **NATIONAL BOARD SCORES:** If you have not taken the MFT exam thru PES, you will receive the exam packet information after Board approval. All applicants are required to pass the Marriage & Family Therapy Examination/PES exam. If you have taken the MFT exam, please contact the National Board Administrative Offices at (212) 367-4389 and have them certify your scores to Georgia. If you have taken the MFT exam thru PES, you would apply for license by exam waiver. If you have not taken the MFT exam thru PES, you would apply for license by exam. If you have an Associate Marriage & Family Therapy license, your MFT application will be combined with your AMFT file and you will not need to submit another exam score.

- ❑ **DEGREE TRANSCRIPT:** All applicants for licensure must have earned a master's degree in marriage & family therapy, counseling, social work, medicine, applied psychology, psychiatric nursing, pastoral counseling, applied child and family development, applied sociology, or from any program accredited by the Commission on Accreditation for Marriage and Family Therapy Education. Such degree shall be from an educational institution accredited by a regional body recognized by the Council on Post Secondary Accreditation. An **official** college transcript certifying the grades, degree conferred and the date awarded must be received in this office directly from the Registrar of the college/school. If you have an Associate Marriage & Family Therapy license in Georgia, you will not need to submit another transcript unless you have obtained a higher degree.

- ❑ **FORM A/INTERNSHIP VERIFICATION:** The instructor of record at the college or university or the Site Supervisor may be verified by the school as part of the master's degree program which includes a graduate level course over 12 consecutive months, under supervision, minimum of 500 hours MFT clinical contact. If you have an Associate Marriage & Family Therapy license in Georgia, you will not need to submit Internship Verification again.

- ❑ **FORM B/PRACTICUM/INTERNSHIP VERIFICATION:** Practicum/Internship must meet minimum requirements set out in Board Rule 135-5-.06(a)(21-24). Complete a separate form for each Practicum/Internship listed on your application.

- ❑ **FORM D-DIRECT CLINICAL EXPERIENCE VERIFICATION:** Complete a separate form for each experience listed on your application. Documented experience must meet the minimum requirements set out in Board Rule 135-5-.06. The Director of Clinical experience must complete Part II. Direction means the ongoing administrative oversight by an employer or supervisor of a special practitioner's work.

- ❑ **FORM E-SUPERVISION OF DIRECT CLINICAL EXPERIENCE VERIFICATION:** Complete a separate form for each Supervisor listed on your application. The number of hours and type of supervision required for licensure as an MFT depends upon the graduate degree that your hold. See Board Rule 135-5-.06.

- ❑ **OTHER STATE LICENSURE CERTIFICATION:** If you are or have ever been licensed in another State(s), please have that/those State(s) officially certify that license directly to the Board's office.

- ❑ **REFERENCES:** Please submit references from two (2) teachers or supervisors who are familiar with their experience in Marriage & Family Therapy.

- ❑ **CONSENT FORM:** Please sign the consent form giving permission for the Board to receive any criminal history record information.

- ❑ If your name has changed since you attended school, please make a note on the application advising of your former name(s) so we can match-up the documents with your application.

- ❑ **IMPORTANT:** Applicants, please note when accessing your application status on our website under the *Online Services* category *Check the Status of an Application* that checklist items that have been moved over to the completed column only means that those documents have been received. This tool is to be used as an option for you to monitor your application for items received as you are going through the licensure process.

  Only the Georgia Composite Board of Professional Counselors, Social Workers and Marriage & Family Therapists has the authority to approve or deny an application for licensure. Every application file must be submitted to the Board for review. The Board meets monthly to review applications and conduct other Board business. Once your application file has been reviewed by the Board, you will receive written communication of the Board's decision within five to seven working days after the Board meeting.

FOR BOARD USE ONLY
Amount Submitted _____
Date _____
Receipt # _____

FOR BOARD USE ONLY
Certificate Number _____
Date Issued _____
Applicant No. _____

GEORGIA STATE BOARD OF PROFESSIONAL COUNSELORS, SOCIAL WORKERS AND MARRIAGE & FAMILY THERAPISTS

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www.sos.state.ga.us/plb/counselors

APPLICATION FOR LICENSE AS A

MARRIAGE AND FAMILY THERAPIST

Application Fee $100 (non-refundable)

Additional License Types (currently or previously issued by the Georgia Professional Licensing Boards): _____

Method Obtained by:
Applicant is applying for above referenced license by:
( ) Examination
( ) Examination Waiver (only if you have already taken the MFT exam thru PES)
( ) Endorsement

Name _____
First Middle Last
Name as shown on exam records or transcripts
(if different) _____
First Middle Last

_____ _____
***Social Security Number** **Date of Birth**
*** This information is authorized to be obtained & disclosed to State & Federal agencies pursuant to O.C.G.A.§19-11-1 & O.C.G.A.§ 20-3-295, 42 U.S.C.A.§ 551 & U.S.C.A.§ 101.**

_____ I am a U.S. citizen.

_____ I am not a U.S. citizen, but am a qualified alien under the federal Immigration and Naturalization Act, and I am lawfully present in the United States.

Physical Address _____
Number and Street Apt. No City/State Zip
P.O. Box not acceptable – Please note that your physical address will be made public as part of your licensure verification.

Mailing Address _____
(if different) Number and Street Apt. No City/State Zip

_____ _____
Telephone Number Day Telephone Number Evening

Email Address _____

PART II - PROFESSIONAL BACKGROUND

PROFESSIONAL BACKGROUND: ANSWER "YES" OR "NO" TO THE FOLLOWING QUESTIONS. IF "YES," TO 1 THROUGH 9, ATTACH A DETAILED EXPLANATION.

❒ Yes ❒ No 1. Are you unable to practice safely as a result of the use of alcohol or other drugs?

❒ Yes ❒ No 2. Have you been denied professional licensure or renewal because of a license disciplinary proceeding?

❒ Yes ❒ No 3. Have you ever had a license to practice social work, counseling, marriage and family therapy, or any other profession revoked, suspended or annulled or otherwise sanctioned, including by private order, by any board or agency in Georgia or any other state, territory, or country?

❒ Yes ❒ No 4. Have you been subject to disciplinary action or had your membership revoked by any professional organization?

❒ Yes ❒ No 5. Have you knowingly failed to renew a license during an investigation of a disciplinary matter against you?

❒ Yes ❒ No 6. To the best of your knowledge is there any disciplinary action or investigation pending against you by any licensing board, agency, or professional organization?

❒ Yes ❒ No 7. Have you ever been convicted of any criminal offense?

❒ Yes ❒ No 8. Have you ever been arrested, charged or sentenced for the commission of a felony, misdemeanor (other than minor traffic or parking violations) or any crime of moral turpitude, including the entry of a plea of nolo contender or a plea entered pursuant to the provisions of the "Georgia First Offenders Act? You must respond, "yes" if you plead and completed probation as a First Offender. If yes, provide certified copies of the court disposition. DUI and DWI are not minor traffic offenses.

❒ Yes ❒ No 9. Have you been the defendant in a malpractice suit and either entered into a settlement agreement or paid court awarded expenses?

❒ Yes ❒ No 10. Do you now hold or have you ever held a license as a professional counselor, social worker or marriage and family therapist in any jurisdiction? If "yes," complete the following:
Jurisdiction _____ License No._____
Date Issued_____ Expiration _____

❒ Yes ❒ No 11. Have you previously applied for the same license for which you are currently applying?
If "yes," name under which application was submitted: _____

❒ Yes ❒ No 12. Have you ever served on active duty in the Armed Forces, the Reserves or the National Guard during wartime or during any conflict when military personnel were committed by the President? If "Yes," you may be eligible for Veterans' Preference Points to be added to your examination score. Submit your DD214 Form to the Board office.

III - GRADUATE EDUCATION

INSTRUCTIONS:

- **If you are applying for Associate Licensure, please complete the application for Associate Licensure.**
- **If your degree is in Marriage and Family Therapy from a COAMFTE accredited program (Whether applying for full or associate licensure), complete Part III – A .**
- **If your degree is in MFT (not a COAMFTE program), Counseling, Social Work or an allied profession, complete Part III - B of the Application.**
- List any additional post degree courses you want considered as part of this Application.

Direct the Registrar of your institution(s) to send an official copy of your transcript directly to the Board office.

QUALIFYING DEGREE	
❒ Doctorate: Specify	Date Awarded:
❒ Masters: Specify	Date Awarded:
Name of Institution:	
Street Address of Institution:	
Is the program accredited by the Commission on Accreditation for MFT Education (COAMFTE)? ? Yes ? No	

POST DEGREE COURSEWORK TO BE CONSIDERED	
COURSE TITLE AND NUMBER	EDUCATIONAL OR TRAINING INSTITUTE

PART III - A – MFT COURSEWORK	
Course Title and Number	**Institution**
THREE (3) GRADUATE LEVEL COURSES IN MARRIAGE AND FAMILY STUDIES	
A "Marriage and Family Studies Course" includes the study of the principles, concepts, or history of marriage and family life, family systems, family relations and family development. Board Rule Chapter 135-5-.05(a)4.	
1.	
2.	
3.	
THREE (3) GRADUATE LEVEL COURSES IN MARRIAGE AND FAMILY THERAPY	
A "Marriage and Family Therapy Course" includes the study of the theory and practice of various treatment modalities in marriage and family therapy. Board Rule Chapter 135-5-.05(a)5.	
1.	
2.	
3.	
THREE (3) COURSES IN HUMAN DEVELOPMENT	
"Human Development Courses" encompass the study of all aspects of human development across the life span. Such courses include, but are not limited to, theories of individual development, theories of learning, theories of personality development, theories of normal and abnormal behavior, human sexuality, and psychopathology. Board Rule Chapter 135-5-.05(a)3.	
1.	
2.	
3.	
ONE (1) COURSE IN MARRIAGE AND FAMILY THERAPY ETHICS	
A course in "Marriage and Family Ethics" includes but is not limited to: state and federal laws, Rules of the Georgia Composite Board of PC, SW & MFT, professional ethics, legal responsibilities and liabilities, professional socialization, professional organization, interprofessional cooperation, licensure legislation and independent practice. Board Rule Chapter 135-5-.05(a)6.	
1.	

ONE (1) COURSE IN RESEARCH			
A course in Research includes, but is not limited to research design, methods, and statistics, but not credit received for thesis or dissertation. Board Rule Chapter 135-5-.05(a)(7).			
1.			
A ONE-YEAR PRACTICUM/INTERNSHIP UNDER SUPERVISION IN MARRIAGE AND FAMILY THERAPY			
1.			
Date Began:	Date Ended:	Total # Hours Clinical Experience:	Total # Hours of Supervision:
Name of Supervisor:		MFT License #	State:
❒ Georgia Board-Approved Supervisor ❒ AAMFT-Approved Supervisor or Supervisor in Training ❒ Not an Approved Supervisor			
2.			
Date Began:	Date Ended:	Total # Hours Clinical Experience:	Total # Hours of Supervision:
Name of Supervisor:		MFT License #	State:
❒ Georgia Board-Approved Supervisor ❒ AAMFT-Approved Supervisor or Supervisor in Training ❒ Not an Approved Supervisor			

PART III – B – COUNSELING, SOCIAL WORK, OR ALLIED PROFESSIONAL DEGREE COURSEWORK

RELATED PROFESSIONAL DEGREES:

Check Applicable : ❒ MFT ❒ Professional Counseling ❒ Social Work ❒ Medicine
❒ Psychiatric Nursing ❒ Psychology ❒ Pastoral Counseling
❒ Other: Specify

TWO (2) GRADUATE LEVEL COURSES IN MARRIAGE AND FAMILY STUDIES – LIST COURSE TITLE, NUMBER AND INSTITUTION	
1.	
2.	
TWO (2) GRADUATE LEVEL COURSES IN MARRIAGE AND FAMILY THERAPY – LIST COURSE TITLE, NUMBER AND INSTITUTION	
1.	
2.	
TWO (2) GRADUATE LEVEL COURSES IN CLINICAL CONTENT SUCH AS THE ETIOLOGY, DYNAMICS, EVALUATION, ASSESSMENT, OR TREATMENT OF EMOTIONAL OR BEHAVIORAL PROBLEMS	
1.	
2.	
ONE (1) GRADUATE LEVEL COURSE IN PROFESSIONAL ETHICS	
1.	

PRACTICUM/INTERNSHIP EXPERIENCE FOR ALLIED PROFESSIONS

INSTRUCTIONS

- Applicants for licensure as an MFT **may** apply up to one (1) year of Practicum/Internship experience toward the experience requirements for licensure.
- List, in chronological order, each practicum/internship which you want the Board to consider toward the experience requirements
- Complete the appropriate verification forms.

❒ Yes ❒ No I am applying my Practicum and/or Internship toward the experience requirements. If "Yes" complete below.

A - PRACTICUM/INTERNSHIP COMPLETED AS PART OF A DEGREE PROGRAM

(1) COURSE TITLE AND NUMBER:

PROGRAM:	DEGREE:	
NAME OF SITE:		
NAME OF ON-SITE SUPERVISOR:		
STARTING DATE:	ENDING DATE:	TOTAL HOURS ON-SITE EXPERIENCE:

❒ Georgia Board Approved Supervisor ❒ AAMFT Supervisor or Supervisor in Training ❒ Not Approved Supervisor

(2) COURSE TITLE AND NUMBER:

PROGRAM:	DEGREE:	
NAME OF SITE:		
NAME OF ON-SITE SUPERVISOR:		
STARTING DATE:	ENDING DATE:	TOTAL HOURS ON-SITE EXPERIENCE:

❒ Georgia Board Approved Supervisor ❒ AAMFT Supervisor or Supervisor in Training ❒ Not Approved Supervisor

(3) COURSE TITLE AND NUMBER:

PROGRAM:	DEGREE:	
NAME OF SITE:		
NAME OF ON-SITE SUPERVISOR:		
STARTING DATE:	ENDING DATE:	TOTAL HOURS ON-SITE EXPERIENCE:

❒ Georgia Board Approved Supervisor ❒ AAMFT Supervisor or Supervisor in Training ❒ Not Approved Supervisor

B – PRACTICUM AND/OR INTERNSHIP(s) COMPLETED OTHER THAN PART OF A DEGREE PROGRAM

(1) COURSE TITLE AND NUMBER:

PROGRAM:	DEGREE:	
NAME OF SITE:		
NAME OF ON-SITE SUPERVISOR:		
STARTING DATE:	ENDING DATE:	TOTAL HOURS ON-SITE EXPERIENCE:

❒ Georgia Board Approved Supervisor ❒ AAMFT Supervisor or Supervisor in Training ❒ Not Approved Supervisor

PART IV – POST MASTERS DIRECT CLINICAL EXPERIENCE

INSTRUCTIONS:

- The number of years of experience that are required for licensure as an MFT **depends upon the graduate degree you hold and whether you have completed a practicum and/or internship**.
- List in chronological order the post-master's experience that you want to use to satisfy the experience requirements.
- Use additional sheets if necessary.
- Submit a separate Form D - MFT Direct Clinical Experience Verification for each site listed below.

❒ Yes ❒ No I am applying my Practicum and/or Internship toward the experience requirements.

(1) Starting Date:	Ending Date:	Total On-Site Experience: YEARS: MONTHS:

Name of Site:

Address: _____
Street City State Zip

Name of Director: Your Position Title:

My Experience Was As: ❒ MFT ❒ PC ❒ SW

(2) Starting Date:	Ending Date:	Total On-Site Experience: YEARS: MONTHS:

Name of Site:

Address: _____
Street City State Zip

Name of Director: Your Position Title:

My Experience Was As: ❒ MFT ❒ PC ❒ SW

(3) Starting Date:	Ending Date:	Total On-Site Experience: YEARS: MONTHS:

Name of Site:

Address: _____
Street City State Zip

Name of Director: Your Position Title:

My Experience Was As: ❒ MFT ❒ PC ❒ SW

PART V- SUPERVISION OF POST MASTERS DIRECT CLINICAL EXPERIENCE

INSTRUCTIONS:

- You must have obtained 200 hours of MFT supervision concurrent with your documented experience. At least 100 of the 200 hours must have been provided by an AAMFT approved supervisor, an AAMFT supervisor-in-training, or a Board approved supervisor. A minimum of 50 of these 100 hours must have been in individual supervision and a maximum of 50 may have been in group supervision.
- **If you are using 100 hours from your approved practicum, be sure that you have completed Form B.**
- Complete the following for each supervisor whose supervision you are using to fulfill this requirement.
- Submit a separate Form E, Parts I and II - MFT Supervision of Direct Clinical Experience Verification for each supervisor listed below.
- Enclose the form from each supervisor with your application in a signed, sealed envelope.

(1) Supervisor's Name:

Credentials: ❒ MFT ❒ PC ❒ CSW ❒ Psychologist ❒Psychiatrist ❒ GA Board-Approved MFT Supervisor **or** ❒AAMFT-Approved Supervisor ❒ Supervisor-in-Training

License Title & #:	State:	Issue Date:	Expiration Date:

Supervision Was In The Practice of: ❒ PC ❒ SW ❒ MFT			
Date Started:		Date Ended:	
Duration: _____Years _____Months		Hours: _____Group _____Individual	
(2) Supervisor's Name:			
Credentials: ❒ MFT ❒ PC ❒ CSW ❒ Psychologist ❒Psychiatrist ❒ GA Board-Approved MFT Supervisor **or** ❒AAMFT-Approved Supervisor ❒ Supervisor-in Training			
License Title & #:	State:	Issue Date:	Expiration Date:
Supervision Was In The Practice of: ❒ PC ❒ SW ❒ MFT			
Date Started:		Date Ended:	
Duration: _____Years _____Months		Hours: _____Group _____Individual	
(3) Supervisor's Name:			
Credentials: ❒ MFT ❒ PC ❒ CSW ❒ Psychologist ❒Psychiatrist ❒ GA Board-Approved MFT Supervisor **or** ❒AAMFT-Approved Supervisor ❒ Supervisor-in-Training			
License Title & #:	State:	Issue Date:	Expiration Date:
Supervision Was In The Practice of: ❒ PC ❒ SW ❒ MFT			
Date Started:		Date Ended:	
Duration: _____Years _____Months		Hours: _____Group _____Individual	
(4) Supervisor's Name:			
Credentials: ❒ MFT ❒ PC ❒ CSW ❒ Psychologist ❒Psychiatrist ❒ GA Board-Approved MFT Supervisor **or** ❒AAMFT-Approved Supervisor ❒ Supervisor-in-Training			
License Title & #:	State:	Issue Date:	Expiration Date:
Supervision Was In The Practice of: ❒ PC ❒ SW ❒ MFT			
Date Started:		Date Ended:	
Duration: _____Years _____Months		Hours: _____Group _____Individual	

PART VI – APPLICANTS FOR LICENSURE BY ENDORSEMENT/RECIPROCITY

INSTRUCTIONS:

- The Board may license without examination any Marriage and Family Therapist currently licensed in another jurisdiction so long as that jurisdiction's requirements are substantially equal to those of Georgia.
- Complete this part if you are applying for licensure by endorsement.

❒ I currently hold License # _____from the State of _____ which was issued on _____.

❒ I have provided verification of this license to the Board by completing **Form N** and requesting that the above-referenced state return that Form to the Board office.

PART VIII - OATH

I, the undersigned Applicant, do hereby affirm under penalty of perjury that all statements made and information contained in this application are true and correct to the best of my knowledge and belief. I acknowledge that I may be required to furnish additional information promptly in order for this application to be processed.

_____ _____

Date Signature of Applicant

Sworn and subscribed to before me this

____ day of _____, _____.

_____

Notary Public

My Commission Expires: _____ NOTARY SEAL

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MARRIAGE AND FAMILY THERAPY PRACTICUM/INTERNSHIP VERIFICATION FORM A

INSTRUCTIONS: **NO FAXED FORMS ACCEPTED**

- Please type or print clearly. For additional forms, please photocopy.
- Practicum/Internship must meet the requirements set out in Board Rule 135-5-.06(a), 21-24 [Graduate level course over 12 consecutive months, under supervision, minimum 500 hours MFT clinical contact.]
- **Applicant** – Complete Part I.
- **On-Site Coordinator of Practicum/Internship** - Complete Part II.

PART I - TO BE COMPLETED BY APPLICANT

Name:

Address:

Street City State Zip

√ Check applicable and complete information below:

❒ Practicum/Internship which was **part of my degree program** OR

❒ Practicum/Internship **before or after the master's degree**.

√ Check Type of Practicum/Internship: ❒ MFT ❒PC ❒SW

Institution: Degree Awarded:

Course Title & Number: Supervisor:

Practicum/Internship Site:

Address:

Position/Title:

Description of Responsibilities:

DATES:	FROM: Month/Year	TO: Month/Year
DURATION:	TOTAL YEARS:	TOTAL MONTHS:

HOURS OF ON-SITE EXPERIENCE

Individuals:	Group:	Couples/Families:

OATH

I attest that the above information is a true and accurate representation of my Practicum/Internship.

_____ _____

Date Signature of Applicant

Subscribed to and sworn before me this

____day of _____,_____Printed Name

_____

Notary Public

My Commission Expires:_____ NOTARY SEAL

FORM A - PART II - TO BE COMPLETED BY THE ON-SITE COORDINATOR

INSTRUCTIONS:

- Please review the Applicant's description of his/her Practicum/Internship experience. If you have any additional information that would assist the Board in making a decision on licensure for this Applicant, please provide that information below.
- Complete A or B below, as applicable.

ADDITIONAL INFORMATION:

A - ACTUAL ON-SITE COORDINATOR

ATTESTATION:

I attest that I served as the On-Site Coordinator for the Practicum/Internship described above and that this description is a true and accurate representation of this Applicant's experience.

_____ _____

Date Signature of On-Site Coordinator

_____

Printed Name

Name of Site:

Address:

Street City State Zip

Work Phone: ( ) Home Phone: ( ) Fax: ( )

B - CURRENT ON-SITE COORDINATOR

ATTESTATION:

I attest that the person who coordinated this Applicant's Practicum/Internship cannot be located and that I am the current On-Site Coordinator and can verify this Applicant's experience based upon a review of the available records. After a diligent and thorough search of available records, I attest that the Practicum/Internship described above is a true and accurate representation of this Applicant's experience.

_____ _____

Date Signature of Current On-Site Coordinator

_____

Printed Name

Name of Site:

Address:

Street City State Zip

Work Phone: ( ) Home Phone: ( ) Fax: ( )

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MARRIAGE AND FAMILY THERAPY
PRACTICUM/INTERNSHIP SUPERVISION VERIFICATION
FORM B

INSTRUCTIONS: **NO FAXED FORMS ACCEPTED**

- Please type or print clearly.
- Practicum/Internship must meet minimum requirements set out in Board Rule 135-5-.06(b) 2-3.
- **Applicant** – Complete Part I. For additional forms, please photocopy. Complete a separate form for each Practicum/Internship listed on your Application.
- **Practicum/Internship Supervisor** - Complete Part II. After you have completed this form and it has been notarized, enclose it in a sealed envelope, sign your name over the flap and return it to the Applicant.

PART I - TO BE COMPLETED BY APPLICANT

Name: Social Security #:

PART II - TO BE COMPLETED BY THE PRACTICUM/INTERNSHIP SUPERVISOR

Name of Supervisor:

Type of License: ❒MFT ❒PC ❒CSW ❒PSYCHOLOGIST ❒ PSYCHIATRIST

License # State: Date Issued: Expiration Date:

CERTIFICATION:

I hereby certify that I supervised the Internship/Practicum of the above-named Applicant who practiced:

❒ Marriage and Family Therapy ❒ Professional Counseling ❒ Social Work

Practicum/Internship Site:

Address: _____
Street City State Zip

FROM: Month/Year	TO: Month/Year	TOTAL MONTHS:

SUPERVISION:

This Applicant received the following supervision from me:

INDIVIDUAL: _____Hours/Week GROUP: _____ Hours/Week

I hereby certify that at the time of the documented supervision I met one of the following criteria:

❒ AAMFT Approved Supervisor ❒ AAMFT Supervisor-in-Training ❒ Georgia Board Approved Supervisor

DESCRIPTION OF PRACTICE SUPERVISED:

OATH

I attest that the supervision described above is a true and accurate representation of this Practicum/Internship experience and supervision.

_____ _____
Date Signature of Internship/Practicum Supervisor

Subscribed to and sworn before me this

____day of _____,_____.

_____
Notary Public

My Commission Expires:_____ NOTARY SEAL

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MARRIAGE AND FAMILY THERAPIST

PRACTICUM/INTERNSHIP - MISSING OR DECEASED SUPERVISOR AFFIDAVIT

FORM C

INSTRUCTIONS: Please type or print clearly. **NO FAXED FORMS ACCEPTED**

APPLICANTS:

- Make every effort to locate the supervisor/s/instructor/s of record as necessary to document the required Practicum/Internship Experience.
- You may show your diligence with returned mail, copies of letters, verifications from your academic institution, etc.
- If, however, after a diligent search you are unable to locate the supervisor/s, you may attest to undocumented supervision of Practicum/Internship by taking the oath below.
- The Board may require additional information upon review.

OATH

Under penalty of perjury, as provided in the Official Code of Georgia Annotated, I hereby aver and swear that I was unsuccessful, after I made a diligent effort, to locate:

Name of Supervisor: _____

who served as my Practicum/Internship Supervisor in the practice of Marriage and Family Therapy

during the period of : _____ to _____
Month/Year Month/Year

and during that period he/she was licensed as a:

- ❒ Marriage and Family Therapist
- ❒ Professional Counselor
- ❒ Clinical Social Worker
- ❒ Psychologist
- ❒ Psychiatrist

License Number: _____ In the State of :_____

During that period he/she was:
(check one) ❒ AAMFT Approved Supervisor or Supervisor in Training ❒ GA Board Approved Supervisor

I have attached copies of letters and/or returned mail that demonstrates my attempt/s to reach this supervisor.

_____ _____
Date Signature of Applicant

Sworn to and subscribed before me this _____
_____ day of _____, _____. Printed Name

_____
Notary Public
My Commission Expires: NOTARY SEAL

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MARRIAGE AND FAMILY THERAPY
DIRECT CLINICAL EXPERIENCE VERIFICATION
FORM D

INSTRUCTIONS: **NO FAXED FORMS ACCEPTED**

- Please type or print clearly. For additional forms, please photocopy. This is a 2-sided form. Do not copy as two separate pages.
- Complete a separate form for each experience listed on your Application.
- Documented experience must meet the minimum requirements set out in Board Rule 135-5-.06.
- **Applicant** – Complete Part I.
- **Director of Clinical Experience** - Complete Part II.

PART I - TO BE COMPLETED BY APPLICANT

Name: Social Security #:

Address: _____
Street City State Zip

Employer:

Address: _____
Street City State Zip

Position/Title:

Description of Responsibilities:

The Clinical Experience was in the practice of: ❒ MFT ❒ PC ❒ SW

DATES OF EXPERIENCE:	FROM: Month/Year	TO: Month/Year
DURATION OF EXPERIENCE:	TOTAL YEARS:	TOTAL MONTHS:

HOURS OF CLINICAL EXPERIENCE IN A TYPICAL WEEK
[Do not indicate a range of hours — e.g. 5 to 10]

CLINICAL ACTIVITY (Weekly)	**TYPE OF CLIENT** **Individual**	**Couple/Family**
A) Client contact as therapist	# of Hours:	# of Hours:
B) Case staffing [group discussion of a case]	# of Hours:	# of Hours:
C) Other clinically related activities (See Board Rule 135-5-.06(a)9)	# of Hours:	# of Hours:

ATTESTATION

I attest that the above information is a true and accurate representation of my Direct Clinical Experience.

_____ ___ _____
Date Signature of Applicant

_____
Printed Name

FORM D - PART II - TO BE COMPLETED BY THE DIRECTOR OF CLINICAL EXPERIENCE

INSTRUCTIONS:

- "Direction" means the ongoing administrative oversight by an employer or supervisor of a special practitioner's work. Direction may be provided by any person acceptable to the standards committee for that specialty in which the practitioner is working. The Director shall be responsible for assuring the quality of the services rendered by the practitioner and shall ensure that qualified supervision or intervention occurs in situations that require expertise beyond that of the practitioner.
- An "Employer" is a person who employs the services of others; one for whom employees work, who has the right to control and direct the person who performs services, and who pays their wagers or salaries or other monetary consideration for their services.
- Please review the Applicant's description of his/her Directed Clinical Experience. If you have any additional information that would assist the Board in making a decision on licensure for this Applicant, please provide that information below.
- Complete A or B below, as applicable and **sign before a Notary Public**.

ADDITIONAL INFORMATION:

A - ACTUAL DIRECTOR

OATH:

I attest that I provided the direction, as prescribed by law, of the Direct Clinical Experience described on this Application and that this description is a true and accurate representation of this Applicant's experience.

_____ _____

Date Signature of Director

_____

Printed Name

Name of Site:

Address: _____

Street City State Zip

Work Phone: ( ) Home Phone: ( ) Fax: ( )

B - CURRENT DIRECTOR

OATH:

I attest that the person who provided this Applicant's direction cannot be located, that I am the current Director and can verify this Applicant's experience based upon a review of the available records. After a diligent and thorough search of available records, I attest that the description above of this experience is a true and accurate representation of this Applicant's experience.

_____ _____

Date Signature of Current Director

_____

Printed Name

Name of Site:

Address: _____

Street City State Zip

Work Phone: ( ) Home Phone: ( ) Fax: ( )

Subscribed to and sworn before me this

____day of _____,_____

_____

Notary Public

My Commission Expires: _____ **NOTARY SEAL**

GEORGIA COMPOSITE BOARD OF PROFESSIONAL COUNSELORS, SOCIAL WORKERS, AND MARRIAGE AND FAMILY THERAPISTS
237 Coliseum Drive
Macon, Georgia 31217-3858
(478) 207-2440 [Telephone] *(866) 888-7130 [Fax]
www.sos.state.ga.us/plb/counselors

MARRIAGE AND FAMILY THERAPY
SUPERVISION OF DIRECT CLINICAL EXPERIENCE VERIFICATION
FORM E

INSTRUCTIONS: **NO FAXED FORMS ACCEPTED**

- Please type or print clearly. For additional forms, please photocopy.
- Complete a separate form for each Supervisor listed on your Application.
- The number of hours and type of supervision required for licensure as an MFT depends upon the graduate degree that you hold. Seen Board Rule 135-5-.06.
- **Applicant** – Complete Part I.
- **Supervisor of Direct Clinical Experience** - Complete Part II.

PART I - TO BE COMPLETED BY APPLICANT

Name: Social Security #:

Address: _____
Street City State Zip

Employer:

Address: _____
Street City State Zip

Name of Supervisor:

The Supervision was in the practice of: ❒ MFT ❒ PC ❒ SW

DATES OF SUPERVISION:	FROM: Month/Year	TO: Month/Year
DURATION OF SUPERVISION:	TOTAL YEARS:	TOTAL MONTHS:

DESCRIBE THE PRACTICE:

DESCRIBE THE SUPERVISION:

ATTESTATION

I attest that the above information is a true and accurate representation of my practice and supervision.

_____ _____
Date Signature of Applicant

_____
Printed Name

FORM E - PART II - TO BE COMPLETED BY THE SUPERVISOR OF CLINICAL EXPERIENCE

INSTRUCTIONS:

- "Supervision" means the direct, i.e., face to face, clinical review, for the purpose of training, teaching, and promoting the development of clinical skill by a supervisor of a supervisee's interaction with client(s). Supervision may include, without being limited to, the review of case presentations, audio tapes, video tapes, and direct observations.
- Please review the Applicant's description of his/her practice and supervision. If you have any additional information that would assist the Board in making a decision on licensure for this Applicant, please provide that information below.

Name of Supervisor:

Address: _____
Street City State Zip

Type of License: ❒ MFT ❒ PC ❒ CSW ❒ PSYCHOLOGIST ❒ PSYCHIATRIST

License # State: Date Issued: Expiration Date: Years of Practice:

ADDITIONAL INFORMATION:

SUPERVISION

THIS APPLICANT RECEIVED THE FOLLOWING SUPERVISION FROM ME:

I supervised the above-named Applicant in the practice of:
❒ Marriage and Family Therapy ❒ Professional Counseling ❒ Social Work

DATES OF SUPERVISION:	FROM: Month/Year	TO: Month/Year
DURATION OF SUPERVISION:	TOTAL MONTHS:	TOTAL YEARS:
INDIVIDUAL: _____Hours/Week	GROUP: _____ Hours/Week	TOTAL HOURS:

I am a:

❒ GA Board-Approved MFT Supervisor Date Approved: _____
❒ AAMFT-Approved Supervisor Term Expires On: _____
❒ In Supervision of Supervision:
GA Board **or** AAMFT Approved Supervisor of Supervisor-in-Training:_____
Date Supervision of Supervision Began: _____

OATH

I attest that I served as this Applicant's supervisor as prescribed by law, and the description of the supervision provided in this Application is a true and accurate representation of my supervision with this Applicant.
I ❒ RECOMMEND ❒ DO NOT RECOMMEND this Applicant for licensure.

_____ _____
Date Signature of Supervisor
Subscribed to and sworn before me this

____day of _____, _____

_____
Notary Public
My Commission Expires: _____ NOTARY SEAL

GEORGIA COMPOSITE BOARD OF PROFESSIONAL COUNSELORS,
SOCIAL WORKERS AND MARRIAGE AND FAMILY THERAPISTS
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MARRIAGE AND FAMILY THERAPIST
POST-MASTER'S DIRECTED EXPERIENCE - MISSING OR DECEASED SUPERVISOR AFFIDAVIT
FORM F

INSTRUCTIONS: **NO FAXED FORMS ACCEPTED**

- Please type or print clearly.
- The years and hours of supervision required for MFT licensure depend on the degree you hold.
- **The Directed Experience Supervisor must: Be a licensed:** Professional Counselor, Clinical Social Worker, Marriage and Family Therapist, Psychologist, Psychiatrist and Meet the post-licensure experience requirements for the degree held. See Board Rule Chapter 135-5-.06.

APPLICANT:

- Make every effort to locate as many of the directors of Directed Experience as necessary to document the required Directed Experience Supervisor.
- You may show your diligence with returned mail, copies of letters, verifications from your academic institution, etc.
- If, however, you have obtained sufficient directed experience to meet licensure requirements, but after a diligent search you are unable to locate enough Supervisors to document the required time, you may attest to undocumented Supervision by taking the oath below.
- The Board may require additional information upon review.

PART I - APPLICANT

NAME: SOCIAL SECURITY NUMBER:

I hold a: **Master's Degree**: ❒ PC ❒ CSW ❒ MFT ❒ Rehabilitation Counseling ❒ Specialist
Allied Degree: ❒ Medicine ❒ Psychiatric Nursing ❒ Psychology ❒ Pastoral Counseling
❒ Child & Family Development ❒ Applied Sociology **Doctorate Degree** : ❒ Ph.D. ❒ Ed.D.

OATH

Under penalty of perjury as provided in the Official Code of Georgia Annotated, I hereby aver and swear that I was unsuccessful, after I made a diligent effort, to locate:

Name of Supervisor:_____

who served as my supervisor while I worked under the direction of: _____
Name of Director

at:_____
Name of Agency or Organization Address City State Zlp

and that this supervisor has the following credentials:

License Type: ❒ Professional Counselor ❒ Clinical Social Worker ❒ Marriage and Family Therapy
❒ Psychologist ❒ Psychiatrist

License #: _____ State:_____ Date Issued:_____ Expir. Date: _____ Years of Practice After Licensed:____

The supervision of my Marriage and Family Therapy Practice was provided during the following 12-month period/s:

YEAR 1 OR PART THEREOF	FROM:	TO:	TOTAL HOURS:
YEAR 2 OR PART THEREOF	FROM:	TO:	TOTAL HOURS:
YEAR 3 OR PART THEREOF	FROM:	TO:	TOTAL HOURS:
YEAR 4 OR PART THEREOF	FROM:	TO:	TOTAL HOURS:

I **have attached copies of letters and/or returned mail that demonstrates my attempts to reach this supervisor.**

_____ _____
Date Signature of Applicant

Sworn to and subscribed before me this

_____day of _____, _____.

_____
Notary Public
My Commission Expires:_____ NOTARY SEAL

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APPLICATION FOR MARRIAGE AND FAMILY THEREAPIST
PERSONAL REFERENCE FORM
FORM G

INSTRUCTIONS: **NO FAXED FORMS ACCEPTED**

- Please type or print legibly.
- Applicants must have references from **two (2) teachers or supervisors** who are familiar with their experience in Marriage and Family Therapy.
- **APPLICANT** - Complete Part I, give this form to your references with an envelope addressed to yourself. Retrieve the completed form from your reference for inclusion with your application.
- **REFERENCE** - Complete Part II, enclose this form in the envelope provided to you by the applicant, seal the envelope, sign your name across the envelope flap and return it to the applicant.
  The Board assumes that in recommending this applicant, references will interpret or substantiate to the Board your recommendation if the Board needs to contact you at a later date.

PART I - APPLICANT

Name:

PART II - REFERENCE

Name:

Address:_____
Street City State Zip

Day Phone: ( ) | Other Phone: ( )

Relationship to Applicant: ❒ Teacher ❒ Supervisor

Dates of Teaching/Supervisory Relationship: FROM: Month/Day/Year TO: Month/Day/Year

PROFESSIONAL POSITION WHEN TEACHING OR SUPERVISING APPLICANT:
Title:_____
Agency/Institution:_____
Address:_____

RECOMMENDATION: I ❒ Recommend ❒ Do Not Recommend the Applicant for licensure.

ADDITIONAL COMMENTS:
[Please write any comments that would assist the Board in making a decision on this Applicant for licensure.]

_____ _____
Date Signature of Reference

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VERIFICATION OF LICENSURE - FORM N

INSTRUCTIONS: **NO FAXED FORMS ACCEPTED**

- Please type or print legibly.
- **Applicant** - Complete Part I. ❒ Mail a form to the Board or Agency of each state or jurisdiction by which you are currently licensed or certified as a Professional Counselor, Social Worker (any level) or Marriage and Family Therapist. ❒ Request the Licensure Board or Regulatory Agency to send the Georgia Board a copy of its current licensure laws and rules. Refer to List of Approved/Disapproved States for Endorsement.
- **State Licensure Board or Regulatory Agency** - Complete Part II.

PART I - APPLICANT

Full Name:

Address:

Date of Birth: Social Security #:

GEORGIA LICENSE APPLIED FOR - CHECK ONLY ONE: ❒ Marriage and Family Therapist ❒ Professional Counselor

Jurisdiction: License Number:

Title of License: Date Issued: Expiration Date:

TO WHOM IT MAY CONCERN

I, the undersigned applicant, am applying for a license with the Georgia Composite Board of Professional Counselors, Social Workers and Marriage and Family Therapists. I hereby consent to the release of any information, favorable or otherwise, which you may have concerning my license or practice. Please return the completed form directly to the Georgia Board at the above address.

_____ _____

Date Signature of Applicant

PART II - LICENSURE BOARD OR REGULATORY AGENCY CERTIFICATION

I, _____, Board Chair or Designated Official

of the _____
Name of Board or Regulatory Agency

certify that the information provided above by this applicant ❒ does ❒ does not conform with that in our record.

If "does not", please explain: _____

___ _____

According to our record, the applicant ❒ has ❒ has not been disciplined by this or any other Board, state agency, or professional organization. **If the applicant has been disciplined, please explain and attach a copy of the Order or Decree:**

_____ _____

Date Signature of Board Chair/Designated Official

_____ _____

Title of Board Street Address

_____

BOARD SEAL City/State/Zip Code

OFFICE OF SECRETARY OF STATE
PROFESSIONAL LICENSING BOARDS DIVISION
GEORGIA COMPOSITE BOARD OF PROFESSIONAL COUNSELORS,
SOCIAL WORKERS AND MARRIAGE AND FAMILY THERAPISTS
237 Coliseum Drive
Macon, Georgia 31217
(478) 207-2440

CONSENT FORM

I authorize the **Georgia Composite Board of Professional Counselors, Social Workers and Marriage and Family Therapists** to conduct a background investigation of me to determine my suitability for licensure. I give my consent for full and complete disclosure of all records and information concerning myself to the Board, their authorized representatives, or any other persons deemed necessary by the Board in determining my suitability, whether such records and information are of a public, private, or confidential nature, to include criminal history records. This authorization will remain in effect for the duration of my active licensure status with this state or until cancelled by me in writing.

_____

Applicant's Full Name (Printed)

_____

_____

Physical Address (P.O. Boxes **NOT** Accepted)

_____ _____ _____ _____

Sex Race Date of Birth Social Security Number

Place of Birth (City/State): _____

Aliases or Maiden Name: _____

_____ _____

(Signature of Applicant) (Date)